TO: All Concerned

FROM: April Fritz, SEER Quality Control

SUBJECT: Updated SEER Inquiry data.

DATE: September 26, 1997

Here is a summary of the changes that were made to the database files for the SEER Inquiry System effective 9/1/97. The same files are available on both the SEER BBS and the SEER Internet site. If you have any questions, please contact me at april.fritz@nih.gov or (301) 402-1625.

1. NEW QUESTIONS DISCUSSED AT THE DETROIT SEER MEETING 05/97.
Nineteen new questions were added in 1997. The following changes were made to the record numbers for records added to the SEER Inquiry database to maintain continuity and consistency in numbering. 'Old' refers to the record number on any 1997 draft documents; 'new' refers to the current record number in the SINQ database.

Old	New	Old	New	Old	New
147	146	157	153	165	159
150	147	158	154	166	160
152	148	161	155	167	161
153	149	162	156	168	162
154	150	163	157	169	163
155	151	164	158	170	164
156	152				

2. UPDATED ANSWERS TO EXISTING SINQ QUESTIONS.
These are questions in the existing SEER SINQ for which the updated answers were revised and approved as of 09/01/1997. Question 0029 at the end was updated with the changes form 9/22/94.

SEER Inquiry System Report

Question ID #: 0012 Date of Inquiry: 04/30/1992

Maintained By: 01 - SEER
Resolved: Yes, Date: 05/99/1992
Inquirer: 00001525 - Seattle (Puget Sound)
Source: Letter 4/30/92
Category: 31 - EOD

Question:

If on rectal exam the prostate feels benign and the tumor is confined to the prostate per TURP/prostatectomy, should we code to extension code 10 as incidentally found microscopic carcinoma even if foci or stage A are not mentioned?

Answer:

For cases diagnosed prior to 1995, use code 10 if the number of foci involved is not given, or as 11 or 12 if the number of foci involved is given. In the example given, the prostate feels benign and tumor is only found incidentally at the time of the microscopic exam. We can't put it in code 20 since it was not palpable.

For cases diagnosed in 1995 and after, this case would be coded 10 in the 'clinical evaluation of extension' field and code 30 in the 'pathological evaluation of extension' field.

Site Recode: 28010 - Prostate
Resolution Description:
Consultant: SEER and UCSF staffs
Comment: Ans revised 5/97 to reflect code changes
Date of Entry: 03/15/1993
Date of Last Update: 05/05/1997

SEER Inquiry System Report

Question ID #: 0042 Date of Inquiry: 10/08/1992

Maintained By: 01 - SEER
Resolved: Yes, Date: 03/16/1993
Inquirer: 00001526 - Utah
Source: QC, 1992, letter
Category: 31 - EOD

Question:

In EOD for prostate, what is the difference between the extracapsular extension in codes 50 and 56?

50 Extension to periprostatic tissue (C1):
Extracapsular extension (beyond prostatic capsule)
Extraprostatic urethra (membranous)
Bladder neck and/or prostatic apex
Through capsule, NOS

55 Extension to seminal vesicle(s) (C2)

56 Extension to periprostatic tissue, NOS (C, not further specified)

We have an example where the path report states "in one focus . . . carcinoma appears to be outside the capsule." Should this be coded 50 or 56?

Answer:

This question applies only to cases diagnosed prior to 1995. In the case described, use code 50.

Comment: The definitions could be clearer and we will be reviewing the entire prostate EOD scheme. C1, C2, and C, NOS refer to the American Urologic Association's staging scheme for prostate cancer. The intent of providing a code for C, NOS was to allow for coding when it was unclear whether the disease was C1 or C2. The codes for C1 and C2 take priority over the code C, NOS.

Site Recode: 28010 - Prostate
Resolution Description:
Consultant: SEER and UCSF staffs
Comment: Ans revised 05/97 due to change in codes
Date of Entry: 03/15/1993
Date of Last Update: 05/05/1997

SEER Inquiry System Report

Question ID #: 0043 Date of Inquiry: 10/08/1992

Maintained By: 01 - SEER
Resolved: Yes, Date: 09/15/1994
Inquirer: 00001526 - Utah
Source: QC, 1992, letter
Category: 31 - EOD

Question:

Utah is finding more and more cases of prostatic carcinoma where there is an elevated PSA, needle biopsies done of one or more than one lobe of the prostate, and a diagnosis of carcinoma made. TUR or prostatectomy is done with further carcinoma identified. There is no mention of whether there were palpable nodules or not. Should cases such as these be 20 or 25 depending on the number of lobes involved, or 30? There seems to be confusion with the word "palpable" in code 20 implying that clinically nodule(s) were felt.

Answer:

This question is based on the coding scheme in effect in 1992. Use code 10 for an elevated PSA followed by random needle biopsies.

For cases diagnosed in 1994 and after, use code 15 when an elevated PSA is followed by a random needle biopsies and there is no palpable or visible tumor noted.

Comment: SEER EOD categories are intended to map onto AJCC TNM categories. In the 3rd edition of the AJCC manual, T1 is defined as "Tumor is incidental finding", and T2 says "Tumor present clinically or grossly, limited to the gland." The 4th ed. clarifies the distinction, with T1 now being defined as "Clinically inapparent tumor not palpable or visible by imaging" and T2, "Tumor confined within the prostate". They have added a T1c, "Tumor identified by needle biopsy (e.g., because of elevated PSA)", with a footnote stating "Tumor found in one or both lobes by needle biopsy, but not palpable or visible by imaging, is classified as T1c."

With the advent of PSA, there have been changes in how patients are being diagnosed and treated. The EOD codes, however, have not kept pace to reflect these changes. Effective in 1994, the EOD was changed to reflect current practice. The AJCC 4th edition clarifies the distinction between T1 and T2 by adding a T1c category to handle the case where a patient presents with an elevated PSA and then has random needle biopsies done on one or both lobes. If there was no clinical palpability and no positive imaging, they are considering that the case is an incidental finding.

Updated questions from the SINQ.DBF

The important distinction is whether or not the nodules were palpable. Only when there is tumor evident clinically does the number of lobes involved enter into the coding.

Site Recode: 28010 - Prostate
Resolution Description:
Consultant: SEER and UCSF staffs
Comment: Ans revised 05/97 to handle code changes
Date of Entry: 03/15/1993
Date of Last Update: 05/08/1997

SEER Inquiry System Report

Question ID #: 0075 Date of Inquiry: 04/01/1994

Maintained By: 01 - SEER
Resolved: Yes, Date: 06/21/1994
Inquirer: 00001522 - Iowa
Source: Letter
Category: 31 - EOD

Question:

Do focus, focal, foci and chips mean the same thing?

Answer:

Focus, focal, and foci are variations of the same word. Focus (noun) describes an area or point of disease, either grossly or microscopically. Focal (adjective) relates to the area/focus of disease; an example is a prostate with focal adenocarcinoma. This means that the majority of the prostate is benign and the adenocarcinoma is confined to one small area/point. Foci (plural) describe more than one area/focus of disease. A prostate with foci of adenocarcinoma means the disease is multifocal (several areas/points of disease.

Chips are small pieces of tissue resected during a TURP. A pathologist might examine many chips of prostate tissue, only one of which contains a microscopic focus of adenocarcinoma.

See related SINQ question 160.

Site Recode: 28010 - Prostate
Resolution Description:
Consultant: SEER and UCSF staffs
Comment: Terminology revised 05/97
Date of Entry: 04/26/1994
Date of Last Update: 05/05/1997

SEER Inquiry System Report

Question ID #: 0076 Date of Inquiry: 04/16/1994

Maintained By: 01 - SEER
Resolved: Yes, Date: 06/21/1994
Inquirer: 99999998 - Other
Source: Fax
Category: 31 - EOD

Question:

Does tumor that arises in the prostatic apex have the same medical implications as tumor that extends to the prostatic apex? Are both situations coded "49" for extension?

Discussion:

Biopsies of the right and left apex are negative. The pathology report following a prostatectomy states that there is extensive neoplasm from apex to mid-gland.

Answer:

For cases diagnosed in 1994, code 48 or 49 in extension. For cases diagnosed after 1994, use code 31. There is no need to distinguish between 'extends to' and 'arises in' for the prostatic apex.

Site Recode: 28010 - Prostate
Resolution Description:
Consultant: SEER and UCSF staffs
Comment: Ans rev 5/97 to reflect code wording chg
Date of Entry: 04/26/1994
Date of Last Update: 05/05/1997

SEER Inquiry System Report

Question ID #: 0078 Date of Inquiry: 04/16/1994

Maintained By: 01 - SEER
Resolved: Yes, Date: 06/21/1994
Inquirer: 99999998 - Other
Source: Fax
Category: 31 - EOD

Question:

What extension codes are used when a prostate tumor is clinically apparent and a prostatectomy is done?

Answer:

For cases diagnosed in 1994, use prostate EOD code 20-22, 25, 27, 30, or 49 for the clinical evaluation if a tumor is palpable or visible on imaging and confined to the prostate.

For cases diagnosed in 1995 and after, code the information from the prostatectomy in the pathologic evaluation of extension.

Site Recode: 28010 - Prostate
Resolution Description:
Consultant: SEER and UCSF staffs
Comment: Ans rev 05/97 to reflect coding diff
Date of Entry: 04/26/1994
Date of Last Update: 05/05/1997

Updated questions from the SINQ.DBF

SEER Inquiry System Report

Question ID #: 0081 Date of Inquiry: 04/16/1994

Maintained By: 01 - SEER
Resolved: Yes, Date: 05/08/1997
Inquirer: 99999998 - Other
Source: Fax
Category: 31 - EOD

Question:
Are "diffusely firm," "firm diffusely enlarged," "hypoechogenicity," "hard ridge," and "induration" terms that imply clinically apparent prostate disease?

Answer:
Use the following lists of terms to distinguish apparent from inapparent tumor in the prostate.

CLINICALLY APPARENT

YES	MAYBE	NO
Nodule	Asymmetrical	1+,2+,3+ enlarged
Hard nodule	Significant asymmetry	30 gm size
Suspicious	Firm	60 gm size
Positive nodule	Slightly irregular	Slightly enlarged
Hard	Nodular	Large
Fixed	Firm ridge	Firm w/o nodule
? nodule	Diffusely firm	Very large
Firm, irregular	Abnormal	Moderately large
Induration		Median lobe
Hard ridge		Firm, diffusely enlarged
		Elevated
		Unilateral enlargement

RADIOGRAPHICALLY APPARENT

YES	MAYBE	NO
Suspicious	Streaky densities in prostate	Mottled-appearing
Hypoechoic	Irregular indentations (bladder)	Prominent S.V.
Suggesting invasion		Negative
Streaky densities in periprostatic fat		Prominent prostate
Hypoechogenicity		Ultrasound negative
		Heterogenicity
		Homogenicity
		Hyperechoic
		Isoechoic
		Calcification

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Comment: Addition tems added 05/97; to go to NAACCR uniform Data Standards Committe

Updated questions from the SINQ.DBF

SEER Inquiry System Report

Question ID #: 0081 Date of Inquiry: 04/16/1994

Site Recode: 28010 - Prostate
Resolution Description:
Consultant: Dr. Platz; SEER Advisory Group
Comment: See answer text
Date of Entry: 04/26/1994
Date of Last Update: 04/25/1997

SEER Inquiry System Report

Question ID #: 0088 Date of Inquiry: 03/28/1994

Maintained By: 01 - SEER
Resolved: Yes, Date: 06/21/1994
Inquirer: 00001525 - Seattle (Puget Sound)
Source: Letter
Category: 15 - Histologic Type
and: 19 - Grade or Cell Indicator

Question:
Are the following codes correct for the 6th digit of histology?

- Low grade to grade 2
- Intermediate grade to grade 3
- High grade to grade 4

Answer:
Code low grade to grade 2, intermediate grade to grade 3, and high grade to grade 4 for most cancers. Non-Hodgkin's lymphoma is the exception to this: low grade, intermediate grade, and high grade refer to the Working Formulation and not to cell differentiation; they are not coded in the 6th digit of histology in this case.

Site Recode: 00000 - All Sites
Resolution Description:
Consultant:
Comment:
Date of Entry: 04/26/1994
Date of Last Update: 09/25/1997

SEER Inquiry System Report

Question ID #: 0101 Date of Inquiry: 10/19/1994

Maintained By: 01 - SEER
Resolved: Yes, Date: 10/23/1995
Inquirer: 00009097 - UCSF
Source: 26-Utah
Category: 31 - EOD
and: 11 - Primary Site

Question:

What is the difference between extension codes "80" and "85" in the prostate scheme? Is bone metastasis coded to "80" (further extension to bone, soft tissue or other organs [D2]) or 85 (metastasis [D2]D, not further specified)?

Answer:

For cases diagnosed 1988-1994: Use code 80 (for 1995 cases and after, code 70) when documentation states tumor directly spread from the prostate to pelvic bone/soft tissue and on to other bones/soft tissue, e.g. ilium, ischium and pubis (false pelvis).

Use code 85 when documentation states tumor indirectly spreads by metastasis to other bones or you don't know how tumor spread to other bones (e.g. physician uses stage D2 with no other documentation). In this example, bone metastasis would be coded to "85".

Site Recode: 28010 - Prostate
Resolution Description:
Consultant: SEER and UCSF staff
Comment: Ans revised 5/97 to reflect code changes
Date of Entry: 03/14/1995
Date of Last Update: 05/05/1997

SEER Inquiry System Report

Question ID #: 0107 Date of Inquiry: 11/01/1994

Maintained By: 01 - SEER
Resolved: Yes, Date: 05/08/1997
Inquirer: 00001501 - San Francisco-Oakland SMSA
Source: San Francisco/Oakland SMSA
Category: 33 - Tumor Size

Question:

Can a 30cm cystic mass be coded as 300 in the size field of EOD?

Does the term "cystic mass" indicate that it is a solid tumor as opposed to the term cyst?

Answer:

Code the size of the ovarian tumor, rather than the size of the cystic mass. If the size is not known, code as 999. Size of tumor is not a criterion for determining stage for ovarian cancer.

A cystic mass is not a solid tumor; it is a mass containing multiple cysts. The term cyst implies a single cyst.

Site Recode: 27040 - Ovary
Resolution Description:
Consultant: Dr. Sanchez,UCSF;SEER Ad Grp
Comment: Discussed:Abstract Coder Workshops 96,97
Date of Entry: 04/14/1995
Date of Last Update: 05/05/1997

SEER Inquiry System Report

Question ID #: 0118 Date of Inquiry: 02/05/1996

Maintained By: 01 - SEER
Resolved: Yes, Date: 06/01/1996
Inquirer: 00001525 - Seattle (Puget Sound)
Source: QC visit to CSS
Category: 31 - EOD

Question:

Per the physical examination, the left lobe was elevated and significantly enlarged compared to the right, from the apex to beyond mid-gland. The right lobe was normal. A CT of the pelvis states that there is a calcification in the right prostate peripheral zone. The radiation therapy evaluation staged this as a 2b. "Enlarged" is on SEER's list of clinically inapparent terms; "elevated" and "calcification" are not on any of SEER's lists.

The needle biopsy was negative on the right and positive on the left, with no mention of the apex.

Should clinical extension be coded as clinically inapparent (15) or clinically apparent tumor (22 vs. 31)?

Answer:

Code this to clinically apparent tumor (22) on the basis of the radiation therapist's stage 2b, since the needle biopsy does not mention involvement of the apex.

COMMENT: There isn't much information provided to form an answer. The calcification information is somewhat misleading and the term has been added to the list of clinically inapparent terms. Unilateral enlargement is more worrisome than bilateral enlargement. "Elevated" is an unusual description.

NOTE: Please see SINQ #81 for a complete list of terms.

Site Recode: 28010 - Prostate
Resolution Description:
Consultant:
Comment:
Date of Entry: 02/16/1996
Date of Last Update: 09/25/1997

SEER Inquiry System Report

Question ID #: 0119 Date of Inquiry: 02/05/1996

Maintained By: 01 - SEER
Resolved: Yes, Date: 06/01/1996
Inquirer: 00001525 - Seattle (Puget Sound)
Source: QC visit to CSS
Category: 31 - EOD

Question:

Case 1.
A prostatectomy was done on 6/29. The physician staged it as a "C" on 7/2 and as T3a on 8/6. It appears the physician is interpreting the following pathology information as unilateral extracapsular extension: "The tumor on the right extends to the inked surface of the gland. In this area the capsule appears absent."

Question 1. Should pathologic extension be coded to unilateral extracapsular extension (42)?

Case 2.
This is similar to the above case. The physician staged to a pathology stage of T3. It appears the physician considers the following pathology statement to be equivalent to capsular invasion on the right side: "Tumor invades the fibrous tissue of the capsule on the right side where it approaches to within 1 mm. of the surgical margin."

Question 2. Should pathologic extension be coded to unilateral extracapsular extension (42)?

Case 3. The prostatectomy final pathology diagnosis states that the tumor involves the periurethral margin. The microscopic describes involvement of the urethral margin. We have been ignoring both of these designations, based on a note from the CSS pathologist which states the following: "When a pathologist states that the urethral surgical margin is positive, this does not necessarily mean that the urethra is involved. The pathologist in this instance is not actually seeing any part of the urethra."

We have been interpreting the portion of the definition for pathologic extension code 49 that states "margins involved (except urethral)" as support for not coding this. However, we are now wondering if SEER put "except

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Updated questions from the SINQ.DBF

Question ID #: 0119 Date of Inquiry: 02/05/1996

urethral" in the definition as an indication that involvement of urethral margins should be coded to 44 (extraprostatic urethra).

Question 3. Should we be coding urethral margin involvement to 44? If so, should periurethral margin also be coded there?

Answer:

Question 1. Yes, use code 42. The inked surface is the surgical margin and positive surgical margins are coded in the range 41-49. The T3a staged by the MD would also lead you to code 42.

Question 2. No. This capsular involvement should be coded to 32, invasion into but not beyond the prostatic capsule, on the basis of the path report.

Question 3. Use code 44 in the pathologic evaluation of extension EOD codes for coding specific mention of involvement of the extraprostatic urethra, distal urethral margin, or the urethral margin (NOS) on a radical prostatectomy specimen. Disregard involvement of the periurethral margin (which is within the prostate) as you have been doing.

Site Recode: 28010 - Prostate
Resolution Description:
Consultant: SEER and UCSF staffs
Comment: 5/97:Clarified intra vs extra-prosatic
Date of Entry: 02/16/1996
Date of Last Update: 05/05/1997

SEER Inquiry System Report

Question ID #: 0029 Date of Inquiry: 03/01/1993

Maintained By: 01 - SEER
Resolved: Yes, Date: 09/22/1994
Inquirer: 00001522 - Iowa
Source: Letter
Category: 62 - Surgery

Question:
Is either a penile implant or a scrotal implant considered reconstructive surgery?

Answer:
The coding of reconstructive surgery was something recommended by the American College of Surgeons, and we will pass this question on to them for resolution.

The response from the American College of Surgeons, dated 9/22/94 is as follows:

> Stedman's Medical Dictionary defines reconstructive surgery as a procedure concerned with restoration, construction, reconstruction, or improvement in the shape and appearance of body structures that are missing, defective, damaged, or mishapen.
>
> The scrotal implant would be coded as reconstructive surgery because it restores the shape and appearance of surgically removed testes.
>
> Prostate cancer patients may have post-treatment impotency. The penil implant treates the impotency rather than restoring the appearance of the penis. It would not be coded as reconstructive surgery.

Site Recode: 28000 - Male genital system
and: 00000 - All Sites
Resolution Description:
Consultant: Carol Johnson, ACos Tech Spec
Comment:
Date of Entry: 03/15/1993
Date of Last Update: 09/25/1997